The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Sutter Health Plus at 1-855-315-5800 or visit sutterhealthplus.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment (copay), deductible, provider, or other underlined terms, see the Glossary of Health Coverage and Medical Terms. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-855-315-5800 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0 individual / $0 individual family member / $0 family per calendar year.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. There is no deductible for covered services.</td>
<td>You don’t have to meet deductibles for covered items and services. But a copayment (copay) or coinsurance may apply. This plan covers certain preventive services without cost sharing. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$8,700 individual / $8,700 individual family member / $17,400 family per calendar year.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.sutterhealthplus.org/provider-search">www.sutterhealthplus.org/provider-search</a> or call 1-855-315-5800 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participating Provider</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary Care Physician (PCP) Visit to treat an injury or illness</td>
<td>$35 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Specialist Visit</td>
<td>$65 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Preventive Care / Screening / Immunization</td>
<td>No charge</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic Test (X-ray, blood work)</td>
<td>Lab: $40 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 (Most generic drugs and low-cost preferred brand name drugs)</td>
<td>Retail: $15 copay per prescription Mail Order: $30 copay per prescription</td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Preferred brand name drugs and non-preferred generic drugs)</td>
<td>Retail: $60 copay per prescription Mail Order: $120 copay per prescription</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at [www.sutterhealthplus.org/about/plans-benefits](http://www.sutterhealthplus.org/about/plans-benefits) or call 1-855-315-5800.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 3 (Non-preferred brand name drugs)</td>
<td>Participating Provider: Retail: $85 copay per prescription  &lt;br&gt; Mail Order: $170 copay per prescription</td>
<td>Non-Participating Provider: Not covered</td>
<td>*See SHP formulary or the Outpatient Prescription Drugs, Supplies, Equipment and Supplement section in EOC for any SHP policy requirements such as prior authorization and step therapy, or coverage limitations and exceptions.</td>
</tr>
<tr>
<td>Tier 4 (Specialty drugs)</td>
<td>Specialty Pharmacy: 20% coinsurance up to $250 per prescription</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility Fee (e.g., ambulatory surgery center)</td>
<td>30% coinsurance</td>
<td>Prior authorization is required. If it is not received, you may be responsible for paying all charges.</td>
</tr>
<tr>
<td></td>
<td>Physician / Surgeon Fee</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency Room Care</td>
<td>Facility: $350 copay per visit  &lt;br&gt; Professional: No charge</td>
<td>If admitted to the hospital, Emergency Room Care cost sharing will not apply. See hospital stay information below for applicable cost sharing.</td>
</tr>
<tr>
<td></td>
<td>Emergency Medical Transportation</td>
<td>$250 copay per trip</td>
<td>Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van) is not covered.</td>
</tr>
<tr>
<td></td>
<td>Urgent Care</td>
<td>$35 copay per visit</td>
<td>For in-area Urgent Care, visit your Medical Group’s contracted Urgent Care facility. For Out-of-Area Urgent Care, visit the nearest Urgent Care facility. Medically necessary treatment of a MH/SUD provided by a 988 center or mobile crisis team, or other providers of behavioral health crisis services is covered in and out-of-network.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility Fee (e.g., hospital room)</td>
<td>30% coinsurance</td>
<td>Prior authorization may be required. If it is not received, you may be responsible for paying all charges. Services that are part of a CARE agreement or plan approved by a court, or medically necessary</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at [www.sutterhealthplus.org/about/plans-benefits](http://www.sutterhealthplus.org/about/plans-benefits) or call 1-855-315-5800.
<table>
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<tr>
<th>Common Medical Event</th>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Medical Event</td>
<td></td>
<td></td>
<td>Treatment of a MH/SUD from a 988 center or mobile crisis team or other providers of behavioral health crisis services, are covered in or out-of-network and without prior authorization.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance use disorder (MH/SUD) services</td>
<td>Physician / Surgeon Fees</td>
<td>Participating Provider: 30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Outpatient Services</td>
<td>Individual Office Visit: $35 copay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group Office Visit: $17.50 copay per visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Outpatient Services: 20% coinsurance (maximum $35 per visit)</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance use disorder (MH/SUD) services</td>
<td>Inpatient Services</td>
<td>Facility: 30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Professional: 30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office Visits</td>
<td>Prenatal and Postnatal Care: No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth / Delivery Professional Services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth / Delivery Facility Services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Home Health Care</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at [www.sutterhealthplus.org/about/plans-benefits](http://www.sutterhealthplus.org/about/plans-benefits) or call 1-855-315-5800.*
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Rehabilitation Services</td>
<td>$35 copay per visit</td>
<td>Quantitative limits exist for the following services: Home Health Care – 100 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Habilitation Services</td>
<td>$35 copay per visit</td>
<td>Skilled Nursing Care – 100 days per benefit period. *See Skilled Nursing Facility Care section in EOC for additional information.</td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing Care</td>
<td>30% coinsurance</td>
<td>Hospice Services – respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time.</td>
</tr>
<tr>
<td></td>
<td>Durable Medical Equipment</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice Services</td>
<td>No charge</td>
<td></td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**
For more information, contact Vision Services Plan (VSP) at 1-800-877-7195 or Delta Dental at 1-800-422-4234.

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Eye Exam</td>
<td>No charge</td>
</tr>
<tr>
<td>Children’s Glasses</td>
<td>No charge</td>
</tr>
<tr>
<td>Children’s Dental Check-up</td>
<td>No charge</td>
</tr>
</tbody>
</table>

Quantitative limits exist for the following children’s services:
- Eye Exam – 1 preventive exam per calendar year.
- Glasses – 1 pair of glasses (or contact lenses in lieu of glasses) per calendar year.
- Dental Check-up – preventive prophylaxis and diagnostic oral evaluation limited to 1 per 6 months.

These are embedded pediatric vision and dental benefits that are provided through the end of the month in which you turn 19 years of age.

**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT COVER</th>
<th>(Check your plan Evidence of Coverage (EOC) for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>- Chiropractic care</td>
<td></td>
</tr>
<tr>
<td>- Commercial weight loss programs</td>
<td></td>
</tr>
<tr>
<td>- Cosmetic surgery</td>
<td></td>
</tr>
<tr>
<td>- Dental care (Adult)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hearing aids</td>
<td></td>
</tr>
<tr>
<td>- Infertility treatment</td>
<td></td>
</tr>
<tr>
<td>- Long-term care</td>
<td></td>
</tr>
<tr>
<td>- Non-emergency care when traveling outside the U.S.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>- Private-duty nursing</td>
<td></td>
</tr>
<tr>
<td>- Routine eye care (Adult)</td>
<td></td>
</tr>
<tr>
<td>- Routine foot care</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at [www.sutterhealthplus.org/about/plans-benefits](http://www.sutterhealthplus.org/about/plans-benefits) or call 1-855-315-5800.
### Other Covered Services

(Limitations may apply to these services. This isn’t a complete list. Please see your plan Evidence of Coverage (EOC).)

<table>
<thead>
<tr>
<th>Service</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>Acupuncture typically provided only for the treatment of nausea or chronic pain; embedded in medical plan. PCP referral and prior authorization are required.</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at [www.sutterhealthplus.org/about/plans-benefits](http://www.sutterhealthplus.org/about/plans-benefits) or call 1-855-315-5800.
To see examples of how this plan might cover costs for a sample medical situation, see the next section.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The Department of Managed Health Care at 1-888-466-2219 or www.dmhc.ca.gov, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through California’s Health Insurance Marketplace, Covered California, at 1-800-300-1506 or www.coveredca.com. For more information about the Marketplace, visit healthcare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance (*See If You Have A Concern Or Dispute With SHP section in EOC for information about grievances) or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Sutter Health Plus at 1-855-315-5800 (TTY: 1-855-830-3500) or California Department of Managed Health Care at 1-888-466-2219 (TTY: 1-877-688-9891) or www.dmhc.ca.gov.

Does this plan provide Minimum Essential Coverage? Yes. Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable. If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services: Please see Notice of Language Assistance addendum.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments (copays) and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network prenatal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow-up care)</td>
</tr>
<tr>
<td>■ The plan’s overall deductible</td>
<td>■ The plan’s overall deductible</td>
<td>■ The plan’s overall deductible</td>
</tr>
<tr>
<td>■ Specialist copayment</td>
<td>■ Specialist copayment</td>
<td>■ Specialist copayment</td>
</tr>
<tr>
<td>■ Hospital (facility) coinsurance</td>
<td>■ Hospital (facility) coinsurance</td>
<td>■ Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>■ Other coinsurance</td>
<td>■ Other coinsurance</td>
<td>■ Other coinsurance</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Office Visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services (anesthesia)
- Diagnostic Tests (ultrasounds and blood work)

Total Example Cost $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
<td>$60</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,500</td>
<td>$280</td>
</tr>
</tbody>
</table>

The total Peg would pay is $2,760

This EXAMPLE event includes services like:
- Primary Care Physician Office Visits (including disease education)
- Diagnostic Tests (blood work)
- Prescription Drugs (including glucose meter)

Total Example Cost $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Joe would pay is $1,820

This EXAMPLE event includes services like:
- Emergency Room Care (including medical supplies)
- Diagnostic Tests (X-ray)
- Durable Medical Equipment (crutches)
- Rehabilitation Services (physical therapy)

Total Example Cost $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$50</td>
</tr>
</tbody>
</table>

The total Mia would pay is $1,050

The plan would be responsible for the other costs of these EXAMPLE covered services.
Notice of Language Assistance

IMPORTANT: Can you read this? If not, Sutter Health Plus can have somebody help you read it. You may also be able to get this written in your language. For no-cost help, please call Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plus puede proporcionarle alguien que le ayude a leerlo. También puede obtenerlo por escrito en su idioma. Llame a Sutter Health Plus Member Services al 1-855-315-5800 (TTY 1-855-830-3500), sin costo alguno. (Spanish)

重要提示：您能读懂這份文件嗎？如果不能，Sutter Health Plus 可以找人幫助您讀它。您還可能得到用您的語言書寫的這份文件。若需要免費幫助，請致電 Sutter Health Plus 會員服務，電話號碼 1-855-315-5800 (TTY 1-855-830-3500)。 (Chinese)

ملحوظة مهمة: هل أنت قادر على قراءة هذا؟ إذا لم تكون قادرًا فاعمل أن صنير هيلث بلاس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنه مساعدتك في قراءة هذا النص. كما يمكن أيضًا أن تتلقى مكتوبًا بأسلوب للحصول على مساعدة مجانية، برجاء الاتصال بخدمات أعضاء صنير هيلث بلاس (Sutter Health Plus Member Services) على هاتف 1-855-315-5800 (TTY 1-855-830-3500). (Arabic)

Բանները սովորաբար են համարվում, որ Sutter Health Plus-ի համակարգում կարելի է տեսնել աշխատակից: Sutter Health Plus-ի Անդամների սպասարկման բաժին՝ 1-855-315-5800 (TTY 1-855-830-3500) հեռախոսահամարով. (Armenian)

notice of language assistance (Cambodian)
重大事项：您已经阅读并理解了吗？如果您没有阅读，Sutter Health Plus 可以为您提供帮助。如果您需要帮助，请拨打 Sutter Health Plus 会员服务中心（1-855-315-5800）或者访问网站。如果您需要翻译，请联系 Sutter Health Plus。  (泰米尔语)

ВАЖНО: Вы можете это прочитать? Если нет, Sutter Health Plus может предоставить Вам кого-то, кто сможет помочь Вам прочитать это. Вы также можете получить это в письменной форме на своем языке. Для бесплатной помощи позвоните в службу поддержки членов Sutter Health Plus по телефону 1-855-315-5800 (TTY 1-855-830-3500). (Russian)


 lingerie: คุณเคยอ่านหรือไม่ ถ้ายังไม่ได้อ่าน Sutter Health Plus สามารถให้คุณมีช่วยเหลือได้ นอกจากนี้ คุณยังอาจต้องการเรื่องเกี่ยวกับความผิดพลาดก่อนไม่สามารถเข้าถึง Sutter Health Plus Member Services ที่ 1-855-315-5800 (TTY 1-855-830-3500) (Thai)